TECHNICAL PAPER 3

# REORGANIZATION AND REORIENTATION OF THE HEALTH SERVICES DELIVERY SYSTEM IN INDIA



आरोग्यम् सुखसम्पदा

राष्ट्रीय स्वास्थ्य एवं परिवार कल्याण संस्थान
NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE
NEW DELHI

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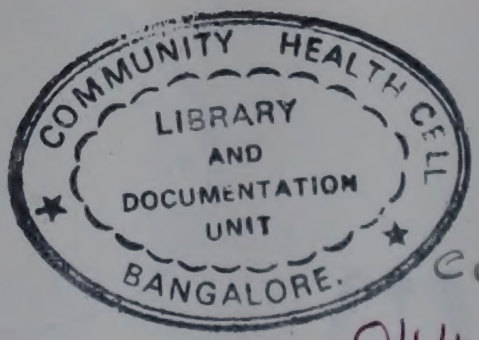




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# CONTENTS

# REORGANISATION AND REORIENTATION OF THE HEALTH SERVICES DELIVERY SYSTEM IN INDIA

J.P. Gupta*, Monica Sharma** and Indira Murali***

*ABSTRACT*

*The goals and functions of the health services system have been reviewed. Several organisational aspects as well as problems in the health sector with reference to physical facilities, manpower, materials and finance have been discussed. Inadequacies in planning and management processes have been highlighted. Structural reorganisation for improved planning and management at the Centre, State and District levels has been suggested. The expansion of management and other functions of various categories of health personnel require reorientation. An outline for reorientation has been given in the paper.*

## I. Health Services Development

Since the initiation of planned development in India in 1951, the principles involved in provision of comprehensive health care as enunciated by the Health Survey and Development Committee in 1946 (Bhore Committee)[1] have been accepted as the framework for development of health services delivery system. Health care encompassing preventive, curative and promotive aspects, was to be provided within available resources as close to people as possible; with particular emphasis on vulnerable groups; irrespective of the ability of people to pay for it; alongwith community participation; and with adequate emphasis on environmental sanitation. A geographically defined population group was to be served by the institutional framework consisting of Primary Health Centres and Sub-centres. The services to be provided by such a framework were to consist of medical care, maternal and child health, family planning, school health, environmental sanitation, control and surveillance of communicable diseases, health education and referral services. Secondary and tertiary levels of care were envisaged to support this primary level care.

With the advent of the Community Development Movement in 1952, the Primary Health Centre complex became an integral part of the socio-economic development framework in a block, for a geographically defined population. The

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First and Second Five Year Plans (1951-56[2], and 1956-61[3]) witnessed an enormous pace of general development and launching of a number of national health programmes, including expansion of infrastructure in health services. In order to find out how these developments affected health care services, the Government of India set up a Committee under the Chairmanship of Dr. A. Lakshmanaswami Mudaliar in June 1959 (Health Survey and Planning Committee)[4], to review health projects and programmes in the First and Second Five Year Plans and to formulate recommendations for future health development in the country.

While the Committee gave a number of recommendations, the essential element in these recommendations related to the need for consolidation of gains already made rather than undertaking further expansion of the existing health services delivery system. Since then a number of committees have reviewed selected aspects of the health care delivery system and have made important recommendations. Notable amongst various committees are the Special Committee on the Preparation for Entry of the National Malaria Eradication Programme into the Maintenance Phase-1963 (Chadha Committee[5]), Reorganisation of Family Planning Services Administration and Basic Health Services, 1966[6], (Mukherjee Committee), Multi-purpose Workers under Health and Family Planning Programme, 1973[7] (Kartar Singh Committee), and Group on Medical Education and Support Manpower 1975[8] (Srivastava Committee). As a result of implementation of the recommendations of these committees as well as initiation and development of the Health Guide Scheme (earlier known as Community Health Workers and subsequently Community Health Volunteer Scheme) in 1977, a sizable infrastructure for health service delivery has come into existence. At grassroot level such an infrastructure is likely to have 82,107 sub-centres, 7,310 primary health centres, 3,920 subsidiary health centres and 603 community health centres by the end of the VIth Five Year Plan ***i.e.*** 31st March, 1985[9],[10]. This infrastructure is supported by other institutions like hospitals, laboratories and training and research organisations of various types at different levels of administration.

As a follow-up of the Alma Ata Conference, 1978[11], the adoption of goal of "Health for All" with primary health care as the key approach, has reinforced the conceptual basis for development of health services, which is in line with the recommendations of Bhore Committee. The principles enunciated by that committee, as well as the philosophy of health being an integral part of socio-economic development, are as true today as they were earlier. The formulation and adoption of National Health Policy in 1982[12], further reinforces the conceptual basis of health service development.

## II. Problems and Issues

Several problems have posed enormous challenges to the development of health services in India. Some of these are: rapid growth of population; overemphasis on the service components of national priorities, such as Family Welfare Programme as well as Malaria Eradication Programme at the expense of

others; need for development of integrated health services; rapid technological advances; rising aspirations of people; geographical imbalances in development of health service; information explosion and rapid development of media and telecommunication systems; increasing cost of health services; lack of coordination between the voluntary and private sectors with the public sector; frequent changes in pattern of central assistance; limited use of modern management methods and techniques in health services, including detailed programme planning etc.

Another important issue relates to coordination between facilities and personnel of indigenous and modern system of medicine within the organised health services, in service as well as education and training functions. The current political, social and administrative milieu, bureaucratisation, and relative lack of involvement of social groups and communities in the planning and mananagement processes, have further added to these challenges.

Constraints of financial resources in comparison to the magnitude of the problems to be tackled on one hand and urge to have faster rate of development, has led to the adoption of an ***ad hoc*** approach in planning of health services. This has resulted in a number of problems and issues of structural and functional nature which are described below under various headings:

1. ***Physical Facilities***

Physical facilities which have come up in peripheral areas have too frequently changing nomenclatures such as subsidiary health centres, sub-centres, new PHC, old PHC, upgraded 30 bedded PHC, rural hospital, referral hospital and community health centre, posing problems in conversion of one type to the other in relation to populations to be catered, geographical areas to be served, functions to be performed, level of facilities to be provided, and different sources of funding and budgets.

Rigidities of standards and costs to be incurred in construction of facilities, irrespective of local needs as well as an unfavourable attitude towards hiring of available buildings, if constructions are not possible, have hindered the progress of development of health services infrastructure. Further, such infrastructure cannot function effectively and efficiently, as supporting residential facilities for staff, particularly in rural areas, are not available. Utilization of approrpirate technologies in construction such as use of prefabricated materials as well as local materials, is by and large not thought of. Inappropriate locations in the context of geographical considerations, communication facilities and population dispersal further compound this situation.

2. ***Manpower***

The health services system is characterised by too many categories of

personnel. This poses serious problems for developing graded structures conducive for career development. With such large and diverse manpower, developing performance appraisal standards is a gigantic task. The problems get further compounded by necessity of having female workers for health problems specific to women on account of socio-cultural considerations, who may have to reside in insecure and inhospitable environments. The staffing patterns for various types of facilities have not been developed on a rational basis. Supervisory practices conducive for development of supportive supervision and teamwork on account of a number of reasons have not developed to the desired extent. The task of preparation of health manpower through orientation and reorientation, has also not been addressed to adequately.

### 3. *Materials*

Planning and management of materials including drugs, equipment, supplies and transport, is not related to need or demand. The procurement and distribution systems need substantial rationalisation. This should ensure that situations of non-availability of essential drugs, especially in rural and remote areas, are reduced to the minimum. Import substitution policy should be reviewed with respect to several essential items. Alternatives such as reimbursement for transport expenditure to clients with medical emergencies and those requiring referrals, should be carefully weighed against the costs incurred in having public/government ambulance services.

### 4. *Finance*

The budget-structures and processes being still on conventional lines, result in a number of problems related to rigidities of budgetary heads and plan and non-plan expenditure. Varying patterns of central assistance and diversions of allocations by the States, are constant problems of financial management in the State Sector. Different scales of expenditure, for same facility or function or activity depending upon different sources of funding such as Government of India, International or bilateral agencies, are not conducive to proper functioning. Enough efforts have not been made to understand the implication of free and paid (partial or full) health services.

### 5. *Planning*

A holistic view for planning in health within the socio-economic framework and providing inter-sectoral articulation, is by and large missing. Such an integrated view point in terms of looking at training, service and research functions in a composite manner is lacking even within the health sector. The National Health Policy provides direction for health, and similar efforts are required in the area of population and medical and health education.

Preparatory action which is not enough is usually undertaken while instituting changes and formulating appropriate strategies. The change from unipurpose health workers to multipurpose health workers (MPW) strategy is an example where some homework was done before deciding on such a change.

Further, the entire exercise of Health Planning is still by and large a mere summation of programme plans without any appropriate balancing of such programme plans. It also does not reflect the desired linkages between various stages of policy formulation, formulation of strategies, broad programming, detailed programming, implementation, monitoring and evaluation - components of managerial processes for national health development (MPNHD).

The process of integration of medical and public health aspects, initiated immediately after independence at different levels of administrative set up, has passed through different phases. The situation is similar with regard to medical education and research. The organisational structure in the technical wings of Health Ministries at Centre and State levels have developed largely around problems and programmes and not around functions such as planning, implementation, monitoring and evaluation. Such units do not have quantitative and qualitative supportive structures, related to secretariat assistance, statistical services, logistics and supplies etc.

The integration of cadres of medical officers in medical and public health department has led to a serious erosion of health administrative capacity at the Centre, State and District level with gradual disappearance of public health/community health orientation. Integration of cadres of grassroot level workers and their supervisors as a result of implementation of MPW strategy has also led to number of problems in their functioning. One of the serious problems for sub-optimal functioning of personnel at different levels, and belonging to different categories, has been their inadequate preparation during basic, pre-service and in-service training, particularly in relation to their job requirements. A high concern with medical education as compared to the education of paramedical and auxiliary personnel also exists. The required changes in attitude of Programme Officers at Centre and State level for the effective implementation of the MPW strategy has not taken place and the Programme Officers still keep on laying heavy emphasis on a particular programme, rather than taking a balanced view of various programmes.

### III. Remedial Measures - Suggested Reorganisation and Reorientation

The structural and functional anomalies and problems and issues arising thereof, as already discussed, must be tackled so that systems become effective and efficient. The actions required lie in health sector, largely although in relation to some of the problems and issues, the action falls within the general socio-economic and administrative framework. For instance, issues related to current political cum-

social and administrative milieu, excessive bureaucratisation, women's emancipation and role of women in development and involvement of social groups, needs action on much wider front, and are beyond the scope of this paper. We are confining ourselves in this paper to the task of suggesting three remedial measures which fall within the jurisdiction of health sector. It is opined that the problems and issues identified to a large extent be tackled if attention is focussed on: (a) reorganisation of structural framework; (b) improvement in management practices; and (c) reorientation of health manpower.

### *Reorganisation of Structural Framework*

Some of the points which need to be considered while reorganising different levels of the administrative set-up are given below:

1. Complete integration of technical apparatus related to health and family planning at various levels starting from centre and going down to periphery.

2. Reorganization of existing structures into functional divisions/sections/units etc. which cut across various programmes enabling ***inter alia*** induction of managerial expertise at Central and State level at least.

3. Responsibilities of peripheral workers and supervisors upto district level on the basis of geographical areas.

4. Supervisors upto district level to be 'generalist' technical personnel with responsibilities for all programmes and specialist technical services in terms of officers responsible for specific programmes or services to be available at Central and State level.

5. The specialist officers with responsibilities for specific programmes to serve in staff capacity (advisory capacity) and hence in future to be called as Programme Advisors. Wherever situations demand ***e.g.*** in relation to ESI, line function (administrative capacity) may be added, but this should be exception rather than rule.

6. The Programme Advisors to remain in constant touch with sections dealing with planning, implementation, evaluation, training and research etc. The responsibility for effective implementation and monitoring of programmes will be that of Regional Directors who are responsible for a group of States/Union Territories or for a group of Districts within the States/Union Territories.

7. Supportive services whether technical (such as, specialist manpower, laboratory facilities and equipment, statistical services etc.), or administrative (such as general administration, accounts, transport and maintenance etc.) at any level of administrative set-up to be under the overall charge of the chief of the organisation. These services will be available to all the functional nuclei/division/sectors/units etc. so as to lead to their optimum utilisation.

8. Training, service and research at the Central and State levels to be under one roof. Hence, though there would be different Directorates/Divisions/Bureaux within an organisation dealing with these or other areas, they would be under the administrative control of the chief of organisation who would always be the senior most officer heading these Directorates/Divisions/Bureaux.

On the basis of these considerations, an attempt has been made to develop organisational charts at various levels of the administrative set up and the same are given in Annexure 1. Comparison of these charts with the existing ones at Annexures 2, 3 and 4 will bring out the scope of modifications mentioned earlier. But before adopting the reorganised pattern, studies, analysis, discussions and consensus on a wider scale, is imperative.

***Improvement in Management Practice***

If such a reorganisation is ever to be put into operation, it is likely to take care of a number of functional anomalies also. However, such a task is likely to pay off greater dividends, if simultaneously, the tasks related to development of guidelines, procedures and manuals etc. are undertaken on the one hand and deliberate attempt to infuse desirable management practices utilising modern management methods and techniques at various levels of administrative set-up, is made. Desirable as it would have been, this aspect has not been worked out by authors as it will vary from one situation to another, in different geographical regions with varying socio-cultural milieu. On the other hand we have considered it worthwhile to devote our attention to reorientation of health manpower.

***Reorientation of Health Manpower***

Health services personnel, as they move upward in the administrative hierarchy, have to strike a balance between technical knowledge and skills as well as managerial expertise, indicated in Figures I, 2 and 3[4] Such a framework in the context of health services delivery system indicates that positions in the health sector from top to bottom can be categorised under the following heads:

1. Positions which have minimum managerial responsibilities (indicated by in column 4 of Annexure 5).

2. Positions which have moderate degree of managerial responsibilities (indicated by in column 4 of Annexure 5).

3. Positions which have high degree of managerial responsibilities indicated by in column 4 of Annexure 5).

Further, management is an integral part of human activity and as such each and every individual has to perform certain managerial functions. At the individual level

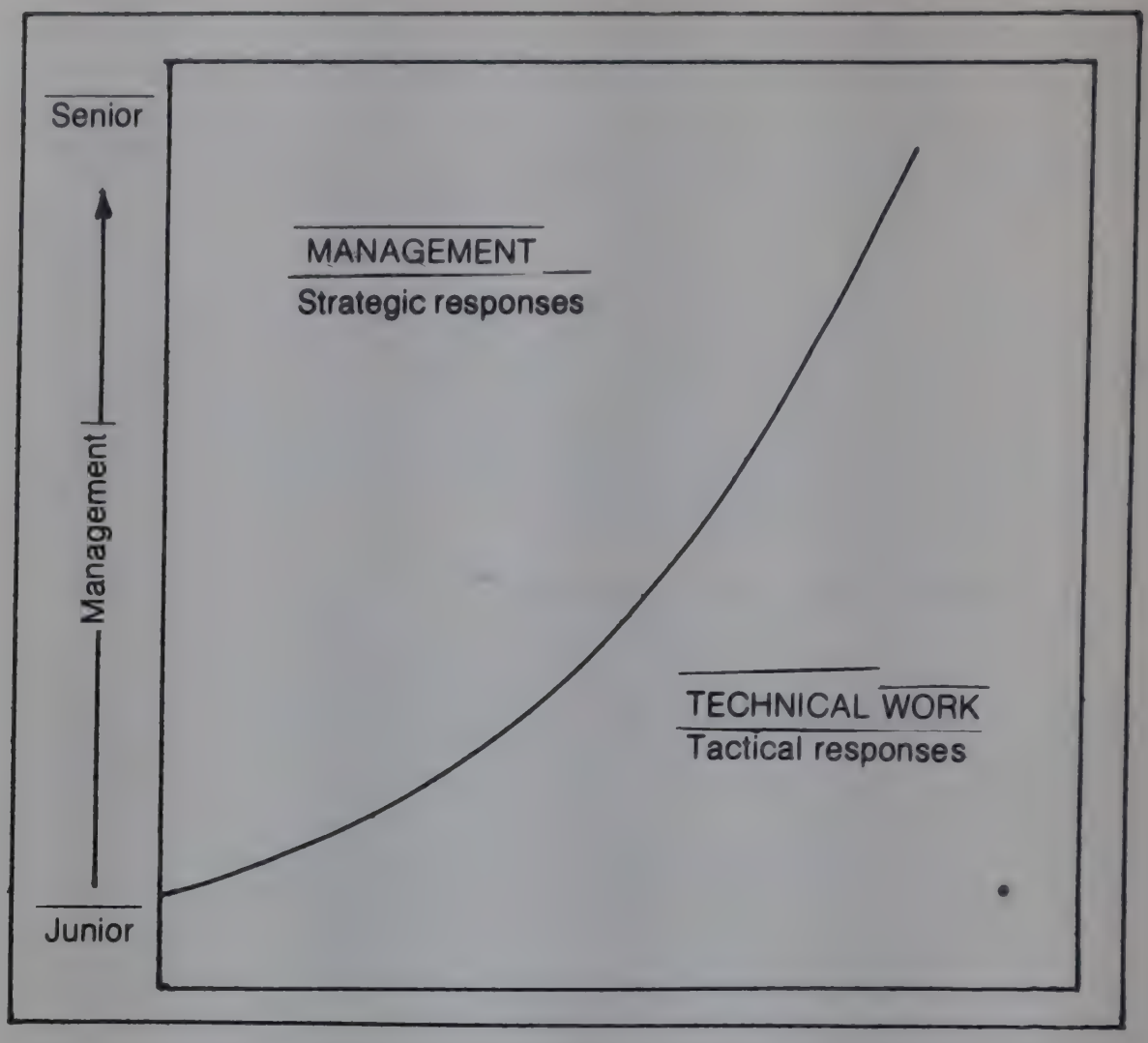


FIGURE 1

SHIFT IN THE NATURE OF PRIMARY WORK

GENERALLY THE MORE JUNIOR LEVELS OF MANAGEMENT (ESPECIALLY IN TECHNICAL FUNCTIONS) ARE CHARACTERISED BY A CONSIDERABLE TECHNICAL WORK CONTENT. THIS DIMINISHES SIGNIFICANTLY WITH PROMOTION (ALTHOUGH THE MANAGER MAY STILL CLING TO HIS ORIGINAL TECHNICAL LOVE)

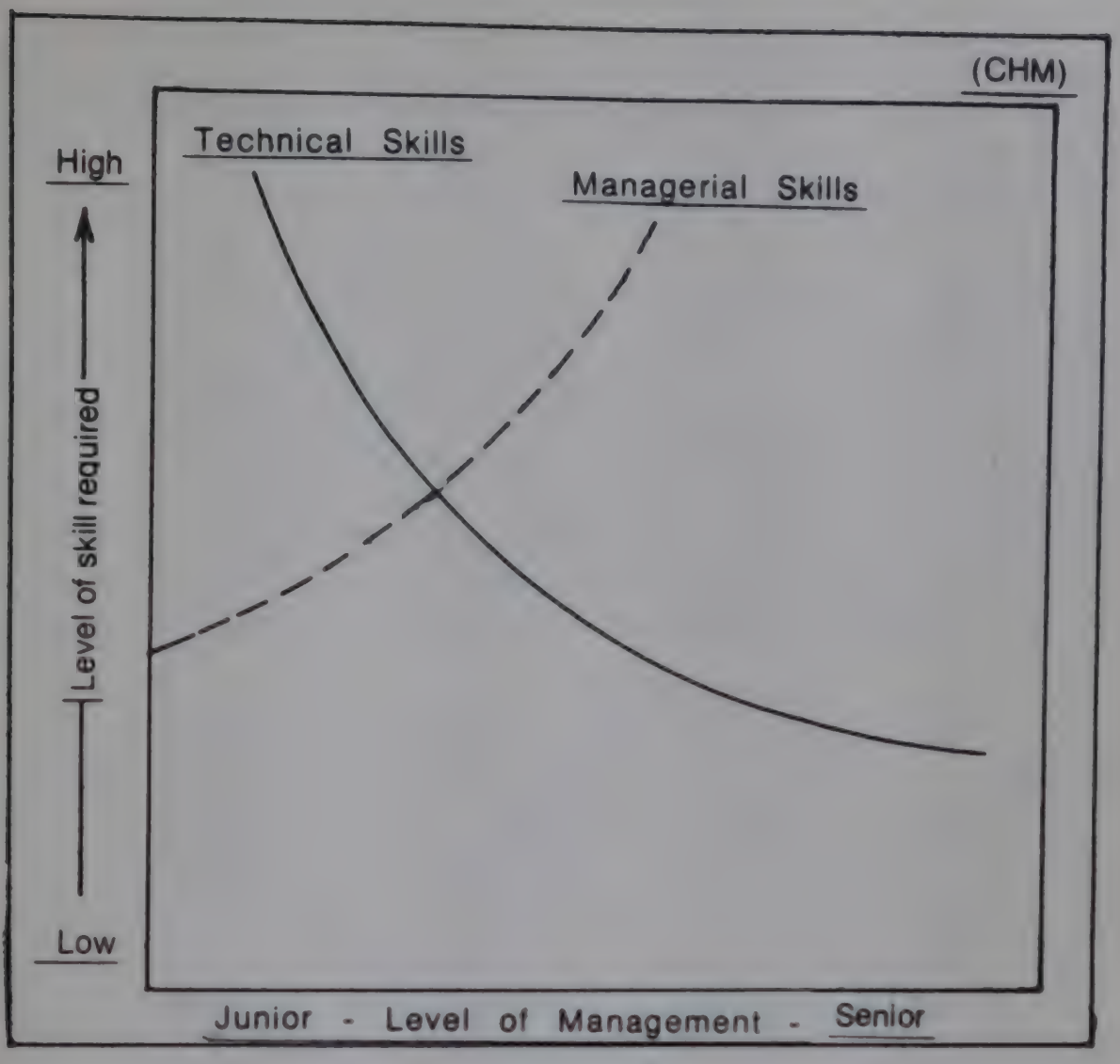


FIGURE 2

CHANGING PATTERNS OF SKILLS REQUIRED TO MATCH PRIMARY WORK SHIFT

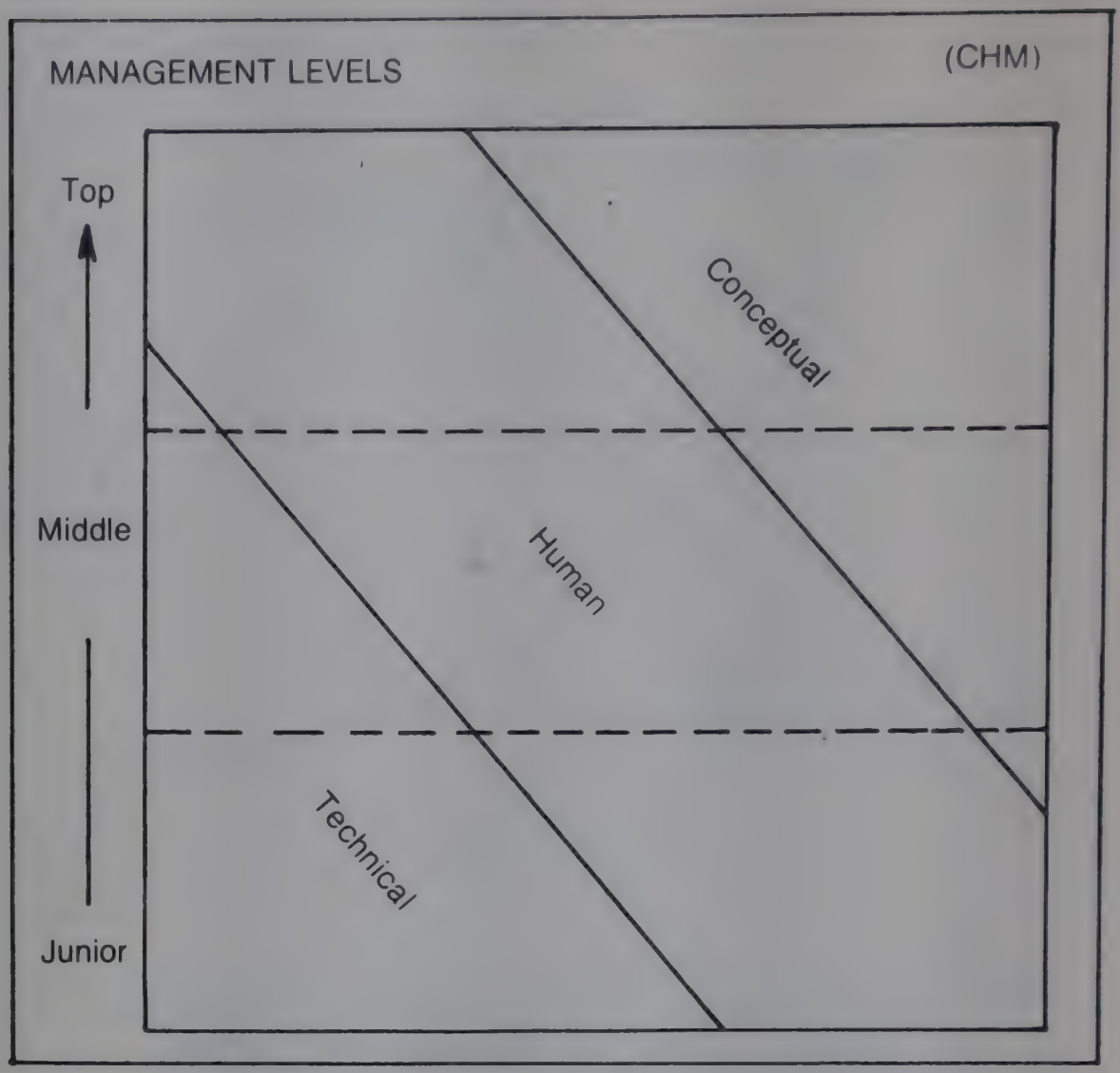


FIGURE 3

EVOLVING NEEDS FOR DIFFERENT SKILLS IN "LINEAR" CAREER PROGRESSION. THIS FIGURE SHOWS THE CHANGING SKILLS NEEDED AS THE INDIVIDUAL MOVES VERTICALLY THROUGH THE HIERARCHY FROM SUPERVISORY OR JUNIOR LEVELS TO THE MOST SENIOR EXECUTIVE POSTS.

for instance the person has to allocate his time and resources for dealing with the problems which pertain to an individual only. In the context of health services development each and every functionary in the field of health has to have varying degree of understanding in relation to the various components of managerial processes such as policy formulation, broad programming, detailed programming, implementation and evaluation.

Needless to say that each and every individual functionary of health services set up must be aware of these components and linkages between these components. However, the degree of awareness of different functionaries at different levels of set up will vary in relation to these components. For instance, a functionary at a very high level has to have a deeper understanding in relation to implementation by the functionaries at grassroot levels. In this context, column 5, 6, 7, 8, and 9 of Annexure 5 indicate the components of managerial processes with which the functionaries at different levels of health services are primarily concerned with and in which they should possess requisite knowledge and acquire necessary skills.

The orientation and reorientation of health services personnel, should be undertaken keeping in mind these considerations. As an example in relation to preparation of physicians for such managerial responsibilities, it is clear that before a physician joins the health services, he must have a clear knowledge of the health services system of the country. At particular levels of the administrative set-up there is a definite need for formal qualifications with community health orientation, and knowledge and skills for health management as an essential qualification. Further, in view of the rapid developments in health services which keep on taking place, it is essential that every functionary undergoes orientation/refresher training every five to seven years. In this context, the training requirements for positions with different degrees of managerial responsibilities are given as under:

***For Positions which are Entirely as well as Primarily Managerial***

***A. Pre-Service***

1. Orientation of medical officers at the time of joining services at grassroot level *i.e.* PHC/CHC. Such a training should be the responsibility of Directorate of Health Services. This training can be organized in the Field Practice Demonstration Area of medical college or alternatively at Health and Family Welfare Training Centres (HFWTCs.)

2. From the level of medical officers in-charge PHC and Medical Officer (qualified and trained in public health) to be posted at the level of community health centre onwards, all medical officers *i.e.* future entrants must have diploma level qualifications with community health orientation and knowledge and skills in health management as an essential qualification. For entry into services such training may be reorganised DPH or may even be institution of a new diploma. In

this context considerable thinking regarding the reorganised contents of DPH was done in 1969 in the Workshop on Postgraduate Education in Community Health (Annexure 6)[13]. This training should be organised in the institutions which are concerned with task of health management such as National Institute of Health and Family Welfare, Gandhigram Institute of Rural Health and Family Welfare Trust, in addition to All India Institute of Hygiene and Public Health, Calcutta where it is already being undertaken. The load dictates opening of few more health management institutions and in this context again a detailed thinking was done in 1967 which however needs to be persuaded again. The alternatives for gearing up this type of training are: (a) strengthening existing institutions concerned with health management training and opening new ones; and (b) opening nuclei or centres of health management as part and parcel of Postgraduate institutions in the country.

For all positions which are entirely and primarily managerial M.D. Preventive and Social Medicine/MD Community Health Administration/MD Public Health etc. may be considered as desirable qualifications in so far as positions in service organisations are concerned.

3. All incumbents of positions at present must undergo staff college course and all future promotions of officers must be tied up with having gone through staff college course of the prototype of those organised at erstwhile NIHAE. This is in conformity with the Resolution of Central Council of Health in early 60's.

4. In case of hospitals, all future entrants should have (a) Orientation training of one month duration for MOs I/C of hospitals less than 50 beds; (b) Certificate course in hospital administration of three months duration for those who are in-charge of hospitals upto 200 beds; (c) Diploma in hospital administration for those who are in-charge of hospitals with bed strength of more than 200. For all service positions, MHA may be a desirable qualification.

Considering the present training facilities in the country, augmentation of a substantial level in the field of hospital administration has to be undertaken.

5. All incumbents of positions at present in the field of hospital must undergo orientation training course in hospital administration of the duration of one month of the prototype of those being organised at NIHFW and all future promotions must be tied up with having gone through such courses.

### *B. Inservice Refresher Courses*

All future entrants should have orientation of one month duration every five to seven years, to appraise them of latest technical aspects of programme management as well as developments in health management.

### *Positions under Minimum Managerial Responsibilities*

For those positions which have minimum managerial responsibilities, orientation course of one month duration before joining the services as well as every five to seven years should be organised.

### *Management Training Needs for Health Personnel*

Some details with regard to orientation, preservice as well inservice including continuing education of health service personnel at various levels of administrative set-up in order to enable them to discharge their managerial responsibilities effectively are given in the table as well as in the text. It is pointed out that this exercise on identification of areas for reorientation of various categories of health personnel for improved management, is confined to select, and important issues which may perhaps be solved partially through training. The issues related to technical competence of personnel which is essential for adequate programme management have not been dealt with in this exercise. Further, the operational guidelines related to training requirements for various categories of personnel, in order to clarify some of the areas discussed in the tables, are given below:

### *Operational Guidelines*

a. The basic training of Dais and Health Guides should emphasise the development of skills required for performing her/his expected functions.

b. Training should not be based on lectures alone but should include practical demonstration in concerned subject. Therefore time allocations have been made accordingly.

c. Recording and use of records have been included under implementation planning since these have to be used for effecting improvements in implementation.

d. In a system which has a hierarchy of trainers, there is likely to be a strong possibility of quality of training suffering since the concepts and contents of training are transmitted through the different levels (from top to bottom). Alternatively, mechanisms need to be developed to have fewer categories of staff, delivering training and to involve senior level staff who are technically well qualified in the training of the basic workers.

e. While teaching personnel management (including supervision) the following need to be considered in detail for health assistants and all categories of health personnel above that level:

   - administrative supervision including disciplinary action;
   - technical supervision.

Information must be made available to the trainees regarding level of authority and administrative procedures - which are interlinked with supervision and disciplinary actions.

It may be noted that a separate row for continuing education has been made even though inservice training has been discussed separately. This is to ensure that other methods of continuing education (excluding formal training) may find a place in the presentation.

f. It may be noted that communication with community includes communication with various groups and sub-groups as well as different village level organisations and institutions. These will include panchayats, schools, mahila mandals, youth clubs etc. In particular, the training should include communication requirements for the illiterate and other socio-economically underprivileged groups.

g. It is felt that the managerial competence of individual health workers at all levels depends critically on the person's ability to understand the patterns of social organisation whether it is at the community or within the health service organisation. It is imperative therefore, that any management training, if it is to be imparted as a module by itself must include details of organisation of groups, group dynamics, group and individual behaviour at the village and family levels.

h. It is felt that training on details regarding administrative procedures and rules and regulations should include the following:

- TA/DA (Travel and Daily Allowances)
- Leave and Transfer
- Administrative sanctions for various purposes
- Entitlements of staff for housing, monetary benefits, loans schooling of children etc.
- Indents for various commodities
- Transport/POL etc.

i. Institutions engaged in preparation of simple teaching and educational strategy/methods should be encouraged and materials thus produced should be made available to the media personnel at all levels directly.

j. Planning for resources refers to area wide planning in the health sector, and not for individual worker's requirements.

k. With regard to organisation of referral services, which has been identified as an

area requiring management training, it may be noted that this is restricted (for health workers and health assistants) to mobilisation of community resources for the same and establishing a functional mechanisms for transporting the patient as well as ensuring the required attention, to the extent possible from the referral centre. This is particularly important because, currently there is a total absence of any such organised activity.

l. It may be noted that in order to function as an effective supervisor, the technical and administrative skills of supervisory cadre must be adequate. Ways and means of ensuring this should be found.

m. With reference to Health Workers' and Health Assistants', training for selection of village level health workers should focus on:

- required attributes of the village workers for their expected functions
- educating the community
- selection criteria.

n. With reference to the managerial training for the technical staff at the primary health centre (item 8 and 15) and CHC, the selected areas (such as that for communication, materials management, etc.) should be included in the basic training, as well as before job placement.

o. It is emphasised that on induction of medical officers into state health services, initial orientation training must be given to the new officers. This should be done at the HFWTC, involving Medical Officers from Block District and State, as well as from administrative training institutions. The duration and contents should be the same as indicated for basic training for medical officers.

p. Priority for training medical officers in management, should be given to those who are holding the charge of various facilities such as PHC, subsidiary health centre etc. Thereafter, other should be trained.

q. For nursing personnel, selected aspects of hospital management must be incorporated in their training.

MANAGEMENT TRAINING NEEDS FOR HEALTH PERSONNEL

TABLE 1

| LEVEL | INSTITUTIONS | Personnel (Category) | Contents | | | | | | | | | Duration | Venue | Trainers |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Planning (For resources | Planning (For implementation) | Personnel management (including supervision) | Communication | Financial management | Materials management | Organisation of training | Inter-Sectoral coordination | Community organisation | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 1- BLOCK | VILLAGE SERVICE | Dai (Basic training) | | *Coordination with the female MPW *Physical arrangement for referral (7 hrs.) | | *With the community *With the health personnel (7 hrs.) | | *Ensure that the required equipment & supplies are readily available (4 hrs.) | | *Role of various sectors on health water supply sanitation agriculture *Identification of personnel *Identification of areas where the family can actually contribute or participate (1 hr. | *Selection of leaders *How to organise community *Plan community based programmes (1 hr.) | 20 hrs. | PHC/ Sub-centre | 1. M.O. 2. B.E.E. 3. F(H.A.) 4. F(MPW) |
| | | (in-service training) Continuing education (for update) | | Along with phased re-orientation training for development of technical skills training for managerial competence for the above may be imparted. This should be conducted at least once in a month, regularly. Technical Aspects on relevant programme details. | | | | | | | | day (7 hrs.) | PHC/ Sub-centre | 1. M.O. 2. B.E.E. 3. F(HA) 4. F(MPW) |

TABLE 2

| LEVEL | INSTITUTIONS | Personnel (Category) | Contents | | | | | | | | | Duration | Venue | Trainers |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Planning (For resources) | Planning (For implementation) | Personnel management (including supervision) | Communication | Financial management | Materials management | Organisation of training | Inter-Sectoral coordination | Community organisation | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 2. BLOCK | VILLAGE SERVICE | Health Guide (Basic training) | | •Co-ordination with health personnel<br>•Physical arrangement for referral<br>•Use of records for more effective implementation (10 hrs.) | | •With the community<br>•With the health personnel (7 hrs.) | | •Ensure that the required equipment & supplies are readily available<br>•Maintenance of records (5 hrs.) | | •Role of various sectors on health water supply sanitation agriculture<br>•Identification of personnel<br>•Identification of areas where the family can actually contribute or participate (3 hrs.) | •Selection of leaders<br>•How to organise community<br>•Plan community based programmes (3 hrs.) | 28 Hrs. | PHC | 1.M.O.<br>2.B.E.E.<br>3.H.As.<br>4.M.P.W.<br>5.Other appropriate administrative staff |
| | | HG (In-service training) | Along with phased re-orientation of training for development of technical skills, training for managerial competence for the above may also be imparted. This should be done once a month, regularly | | | | | | | | | 7 hrs. | PHC | Same as above |
| | | Continuing education (for update) | Wherever applicable, an effort may be made to communicate and reinforce selected simple health measures (e.g. a simple illustrated aid given with the monthly drugs supplies). | | | | | | | | | | | |

TABLE 3

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3. BLOCK | SUB-CENTRE | Female Health Worker (Basic training) | | *Activity planning and work scheduling<br>*Coordination with village level worker, MPW(M)<br>*Organisation of referral services<br>*Recording & reporting<br>-procedure<br>-importance<br>-uses<br>(40 hrs.)<br>3 weeks | *Supervision & guidance of village level worker<br>*Selection of 'dai'<br>(5 hrs.)<br>1 week | *Concepts & methods<br>*With community<br>*With village health workers<br>*Other health personnel<br>*Making educational aids<br>(5 hrs.)<br>1 week | | *Procedural aspects for procurement<br>*Ensure (timely/ advance planning) availability of supplies<br>*Maintenance of records and registers<br>*Storage of drugs & supplies, vaccines<br>(10 hrs.)<br>1½ week | *Plan & conduct training for village level worker<br>*Training methods<br>*Use of training aids<br>*Making training aids<br>(10 hrs.)<br>1½ week | *Role of various sectors on health water supply, sanitation, agriculture<br>*Identification of personnel<br>*Identification of areas where the family can actually contribute or participate<br>(6 hrs.) | *Selection of leaders<br>*How to organise community<br>*Plan community based programmes<br>(2 hrs.) | 78 hrs<br>8 weeks | PHC 1<br>2<br>3 | From the PHC, the M. Officer B.E.E.<br>In addition, faculty from HFWTC and other institute such as District Health Organisation<br>Mobile training team/ functional training units |
| | | Female Health Worker (in-service training) | | Along with phased re-orientation training for development of technical skills, training for managerial competence for the above, may be imparted. This should be conducted regularly, at least once in two months. | | | | | | | | | | |
| | | Continuing Education | | Selected simple health measures, as well as 'update' information should be made available routinely to health workers, presented as leaflets and pamphlets and newsletters. | | | | | | | | | | |
| 4. | | MALE HEALTH WORKER | | Since the managerial functions are very similar to those by the female health worker, we recommend the above for the male health worker also. | | | | | | | | | | |

TABLE 4

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5. BLOCK | PRIMARY HEALTH CENTRE/SUB-CENTRE | Female Health Assistant (Basic Training) | | •Activity planning and work scheduling<br>•Coordination with village level workers MPW female, male health assistant<br>•Organisation of referral services<br>•Recording and reporting<br>- procedures<br>- importance<br>- uses<br>- analysis<br>•Coordination with block level functionaries who carry out developmental activities<br>•Coordination with ICDS and school teacher | •Supervision & guidance of MPW(F)<br>•Supervision & guidance of dai<br>•Concepts, principles and methods of supervision<br>•Performance appraisal<br>- concepts and methods<br>•Selection of village level workers | •Conducting and recording meetings<br>•Concepts and methods in communication<br>•Making communication material<br>•Making educational aids<br>•Communication with:<br>- Community<br>- Village health worker<br>- Other health personnel<br>- Functionaries from other developmental agencies<br>- schools | | •Procedural aspects for procurement<br>•Ensure (Timely advance planning) availability of supplies<br>•Maintenance of records and registers<br>•Storage of drugs, supplies and vaccines | •Training methods<br>•Use of training aids<br>•Making training aids<br>•Plan & conduct training for<br>- village level workers<br>- community<br>- organisations especially women<br>- ICDS - anganwadis<br>- school children | •Role of various sectors on health water supply, sanitation, agriculture<br>•Identification of personnel<br>•Identification of areas where the family can actually contribute or participate | •Selection of leaders<br>•How to organise community<br>•Plan community based programmes | | HFWTC and PHC | 1.Faculty of HFWTC<br>2.Medical officer & BEE from Primary Health Centre<br>3.In addition teachers from other institutions/ organisations from district and State (including district health organisation)<br>4.Mobile training teams/ functional training units |
| | | | | (80 hrs.) | (10 hrs.) | (10 hrs.) | | (20 hrs.) | (20 hrs. | (5 hrs.) | (5 hrs.) | (150 hrs.) | | |
| 6. | | Female Health Assistant (in-service) | Along with phased reorientation training for development of technical skills, training for managerial competence for the above may be imparted. This should be done regularly, at least once in four months. The emphasis in training methodology should be through periodic supervisory visits of concerned officials, rather than formal structured training. | | | | | | | | | | | |
| | | Continuing education (for update) | Selected simple health measures as well as 'update' information should be made available routinely to health assistants. These should be similar to the ones available for health workers, and may be presented as leaflets, pamphlets and newsletters. | | | | | | | | | | | |
| | | Male Health Assistant | Since the managerial functions are very similar to those performed by the female health assistant, we therefore recommend the above for the male health assistant also. | | | | | | | | | | | |

TABLE 5

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BLOCK | PRIMARY HEALTH CENTRE/SUB-CENTRE | Block Extension Educator/ Health Educator (Basic Training) | | *Activity planning & work scheduling<br>*Coordination with village level, & all health personnel<br>*Recording and reporting<br>- procedures, importance, uses,<br>- analysis<br>*Coordination with block level functionaries including: school, BDO, Panchayat | *Supervision & guidance of educational<br>*Activities of health workers and health assistants<br>*Guidance should include assisting in preparation of educational aids<br>*Concepts principles and methods of supervision<br>*Selection of village level workers | *Conducting and recording meetings<br>*Concepts and methods in communication<br>*Making communication material<br>*Making educational aids<br>*Communication with<br>- community<br>- village health worker<br>- Other health personnel<br>- Functionaries of other developmental organisations<br>- panchayats etc.<br>- schools | | *Procedures for procurement<br>*Ensure availability of supplies<br>*Maintenance of records & returns | *Training methods<br>*Use of training aids<br>*Making training aids<br>*Plan & conduct training for<br>- village level workers<br>- village leaders<br>- community organisation<br>- school | *Role of various sectors on health, water supply sanitation, agriculture<br>*Identification of personnel<br>*Identification of areas where the family can actually contribute or participate | *Selection of leaders<br>*How to organise community<br>*Plan community based programmes | | HFWTC | 1.Faculty of HFWTC<br>2.Communication experts<br>3.Teachers from other health organisations State District<br>4.Mobile training teams/ functional training teams/ unit |
| | | | | (30 Hrs.) | (10 hrs.) | (30 hrs.) | | (10 hrs.) | (30 hrs.) | (10 hrs.) | (5 hrs.) | (125 hrs.) | | |
| | | Block Extension Educator (in-service)<br><br>Continuing education (for update) | | In-service training need not be on a regular basis: the emphasis should be on updating the knowledge on technical aspects as well as demonstration of successful health projects/experiences related to community participation, communication and health education.<br><br>Regular information on technical as well as operational aspects particularly related to health education and communication should be made available. These may be in the form of pamphlets, leaflets or newsletters. | | | | | | | | | | |

TABLE 6

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8. BLOCK | PRIMARY HEALTH CENTRE | Technical staff i.e.<br>- Lab. Technician<br>- Radiographer<br>- Optometrist<br>- Pharmacist<br>- Statistician<br>++<br>(Basic Training) | •Concepts & principles of planning<br>•Methodology for determining resource requirements in accordance with ones own job responsibilities<br>(5 hrs.) | •Activity planning & work scheduling<br>•Coordination with other health personnel (particularly from area based programmes)<br>•Recording and reporting<br>- procedure<br>- importance<br>- uses<br>- analysis<br>•Community based approach for work-scheduling<br>(5 hrs.) | •Basic concepts of supervision & guidance<br>(2 hrs.) | •Basis of communication concepts & methods<br>•Communication with the community and in particular patients<br>•Importance to be given to technical contents to be communicated to the patients<br>•Importance of teamwork | | •Procedural aspects for procurement of supplies for their respective job functions<br>•Ensure availability of supplies<br>•Storage of supplies<br>•Maintenance of equipment used by them for concerned job functions<br>•procedural aspects to ensure maintenance of equipments<br>(40 hrs.) | •Basis of teaching and training should be taught so that they can participate effectively in the teaching of health staff at PHC regarding the concerned job functions.<br>(5 hrs.) | | | (57 hrs.) | Brief introduction at Primary Health Centre Workshop laboratory or Department relevant to the job functions | •Teaching faculty from the training schools of concerned technical staff in collaboration with the staff from Health Sector |
| | | Technical staff at PHC (in-service training) | Before the placement of personnel at the primary health centre a job orientation with emphasis on the above areas of management need to be organized. This should be supplemented with periodic refresher training. | | | | | | | | | | | |
| | | Continuing education (for update) | Regular information on technical as well as operational aspects related to their job functions should be made available in the form of leaflets, pamphlets or newsletters. | | | | | | | | | | | |

TABLE 7

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 9. BLOCK | PRIMARY HEALTH CENTRE | Administrative - clerical staff (Orientation before job placement) | | *Record & registers - maintenance - uses - procedure (1 hr.) | *Outline of concepts to Promote the same (1 hr.) | *Basic methods and principles of communication - to promote team work - to promote better understanding with the community (1 hr.) | | *Brief introduction *Procedures for maintenance and supplies (1 hr.) | *To enable the staff to deliver a lecture on procedural and administrative aspects for health workers (1 hr.) | | | 5 hrs. | District level health organisation | District Administrative personnel |

TABLE 8

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 10. BLOCK | PRIMARY HEALTH CENTRE | Medical officer incharge of Primary Health Centre<br>...<br>(Basic and Pre-service) | •Concepts and principles of planning for health<br>•Methodology for determining resource requirements for individual programmes and for the area as a whole covered by PHC<br>•Information required and their sources for planning<br>(20 hrs.) | •Activity planning & work scheduling<br>•Recording reporting<br>- procedures<br>- importance<br>- uses<br>- analysis<br>- maintenance<br>•Concepts of monitoring & evaluation<br>•Organisation of referral services<br>•Coordination with block level functionaries for different development functions<br>(20 hrs.) | •Concepts principles and methods of supervision including performance appraisal<br>•Administrative procedures regarding staff management rules regulations limits of authority etc.<br>•Concepts and principles of team work<br>•Leadership<br>(16 hrs.) | •Basic concepts principles and methods to communicate with subordinates & superiors<br>•Conducting staff meetings<br>•Participation in different meetings<br>•Communication with<br>- patients<br>- community members<br>- other health personnel<br>•Understanding human behaviour (individual & groups & community dynamics<br>(15 hrs.) | •Basic about financial procedures, rules budgeting<br>•How to maintain accounts<br>•Auditing its importance<br>•Limits of financial authority at different levels.<br>(5 hrs.) | •How to assess the need for drugs, supplies vaccines & equipments<br>•The procedure for procurement of the above<br>- storage<br>- maintenance of records<br>- stock verification<br>•Quality control rules & procedures<br>•Transport management<br>•Maintenance of equipments & transport<br>(15 hrs.) | •Training methods<br>•Use of training aids<br>•Making training aids<br>•Plan & conduct training programmes for village level workers health personnel<br>(10 hrs.) | •Role of various sectors on health water supply, sanitation, agriculture<br>•Identification of personnel<br>•Identification of areas where the family can actually contribute or participate<br>(6 hrs.) | •Selection of leaders<br>•How to organise community<br>•Plan community based programmes<br>(4 hrs.) | (105 hrs.) | •Medical College, District Hospital and Health Organisation & Primary Health Centre & Functional units under different health programmes | •Faculty from medical college & staff from Health Administrative training institutions<br>•Medical officers PHC & District level Health programmes officers<br>•District/s administrative personnel |
| | | Information on technical as well as operational aspects related to medical sciences and health services should be made available regularly. These should be in the form of bulletins, journals etc. Continued regular interactions between district and PHC/CHC officers, must be encouraged. | | | | | | | | | | | | |

TABLE 9

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11. BLOCK | COMMUNITY HEALTH CENTRE | Nursing Personnel (Basic Training) (Staff Nurse Category) | | *Activity planning and work scheduling for hospital services (30 beds) & for extension services<br>*Recording reporting procedure importance use analysis and maintenance (hospital and community extension services)<br>*Importance of referral services<br>*Coordination with other health personnel<br>(10 hrs.) | *Basic principles of supervision and guidance<br>(2 hrs.) | *Basic methods & principles of communication<br>*Methods of communication with patients & community & other health personnel<br>(5 hrs.) | | *To decide on requirement of supplies drugs equipments for hospital & extension services<br>- the procurement (procedures)<br>- storage<br>- stock registers & recording<br>(5 hrs.) | *Basic methods of training<br>*Lesson planning<br>(5 hrs.) | | | (27 hrs.) | Colleges of nursing in collaboration with District Block & State Health organisation | *Faculty from colleges of nursing<br>*Medical & nursing officers from State District & Block level health services<br>*Administrative staff from District & State level health organisation |
| | | Nursing personnel (in-service training) | Short orientation training before placement of Community Health Centre is to be imparted. In addition, refresher training may be organised as and when necessary according to professional needs. | | | | | | | | | | | |
| | | Continuing education (for update) | Information on technical and operational aspects related to medical and nursing services and health programmes should be made available regularly. | | | | | | | | | | | |

12. ***Other Medical Officers at Block Level***

This includes officers at the primary health centre, rural dispensary and subsididary health centre. The training requirements are the same. For personnel who are already in position, reorientation training may be given.

13. ***Medical Officer In-charge of Community Health Centre***

The basic training would remain the same. Reorientation or orientation training must include training in hospital management, as well as for community health.

14.***Medical Officers Working as Specialists***

These officers should be trained in the same areas as other medical officers, but the curriculum should focus on hospital management and referral services.

15. ***Technical Staff at Community Health Centre***

The technical staff at the community health centre include, for this presentation, pharmacists, laboratory technicians, X-ray technicians, ophthalmic assistants, and statistical assistants. The management training requirements for these personnel are identical to those specified for technical staff at the Primary Health Centre, discussed under point No. 8. In addition, it is felt that:

1. Management training should include requirements for the "30 beds" at the community health centre, in addition to training for community based services.

2. Training to appreciate their role in the referral system and communication with the referred cases.

16. ***Administrative Staff at Community Health Centre***

Administrative staff at the Community Health Centre includes a cashier and clerical staff. The managerial training requirements are the same as that for the Primary Health Centre, as discussed in point 9.

17. ***Extension Educator at Community Health Centre***

Same as that for the Block Extension Educator, discussed under 7.

18. ***Community Health Officer at CHC***

It is proposed to have a category of persons, to be designated as community health officers, who will assist the Medical Officer in various administrative and managerial functions. Training should be similar to that of the Medicl Officer (point 10) for management.

### *19. Health Personnel Requiring Management Training at District Level*

The Health Personnel at District level have been divided into the following groups:

a. Chief Medical Officer

b. Deputy Chief Medical Officer and District Programme Officers (tuberculosis, malaria, family welfare, leprosy, school health).

c. Nursing Staff

d. Media Officers

e. Technical support staff

f. Administrative support staff.

The managerial functions, and the broad areas of training remain the same for these categories of personnel, as their counterparts from the block level. The difference lies in the depth with which a particular subject is to be treated. This applies fundamentally to in-service training programmes, since basic training remains the same for each professional or semi-professional body. Emphasis will have to be given for training in the following:

1. Area-wide resource planning

2. Implementation planning, including coordination

3. Supervision, motivation, social relations and other aspects of personnel management

4. Financial management - budgeting, accounting, auditing

5. Materials managements, with an emphasis on logistics

6. Communication

7. Health information system - its importance and use, for planning, monitoring and evaluation.

8. Principles of organisation and management, decision-making.

9. Community participation.

The training (inservice) required for district officers will be conducted at State

and Central level institutes. Some are identified:

1. National Institute of Health and Family Welfare

2. Management training institutes (IIM, IIPA etc.)

3. Central Training Institutes

4. State Administrative training institutions.

The duration of the training may be for about six weeks. In addition, courses may be run for specific managerial functions.

20. ***Managerial Training Needs for Health Personnel at State and Central Level***

The categories of health personnel at State and Central level are categorised as follows*:

1. Director General of Health Services, Director ESI, Director CGHS etc. at Central level and Director Health Services at State level.

2. Programme Officers include officers in-charge of Malaria, MCH and Family Planning (F.W.), Tuberculosis, Leprosy, Falariasis etc.**

3. Nursing Officers - Advisor Nursing at Centre and Deputy/Assistant Director Nursing at State level.

4. Media Officers

5. Technical support staff

6. Administrative staff

7. Trainers of various teaching and training institutions

8. Teachers from Medical Colleges.

*It may be noted that the classification of health personnel is broad and general. This is because, even though the organisational responsibilities of officers at these levels are more or less similar in nature.

**Also it may be noted that since the administrative designation of officers does not necessarily reflect their management functions in relation to health programmes, *e.g.* Joint Director, Malaria and ADG(TB), have similar responsibilities towards management of the concerned health programmes though their levels in the hierarchy are different. Hence all these officers are categorised under common group "programme officers".

The points discussed regarding management training needs at district level also apply to the State and Central level officers. However, more emphasis should be given to functions related to policy formulation, setting standards and norms. Officers for the State and Central level Imust have deep understanding of various sectors of development in order to appreciate the vital interlinkages between health and various facets of socio-economic development. This would culminate in the formulation of balanced State and Central plans.

***Duration***

Since senior officers often cannot be relieved of their heavy responsibilities for long period, it is suggested that courses of varying durations may be organised to ensure participation ***e.g.*** Staff College Courses dealing with all required areas of management as well as short courses for specific managerial functions.

***Venue***

Same as District level officers.

It may be noted that there are several institutions conducting management training including governmental and non-governmental. There is an urgent need to set up a collaborative efforts between them and strengthen the network of such training institutions in order to provide better quality training.

***Summary***

Several problems and issues related to the structure and functions of the health services organisation have been identified. Reorganisation of the structure in accordance with the expected functions of the health services organisation at the Central, State and district levels have been suggested. It is envisaged that this reorganisation would culminate in improved management of materials, finance, manpower and other resources, and contribute to development of effective and efficient planning and management process. It is also felt that reorientation of various categories of health personnel is imperative for such development. Several areas in which managerial training should be imparted, have been indicated.

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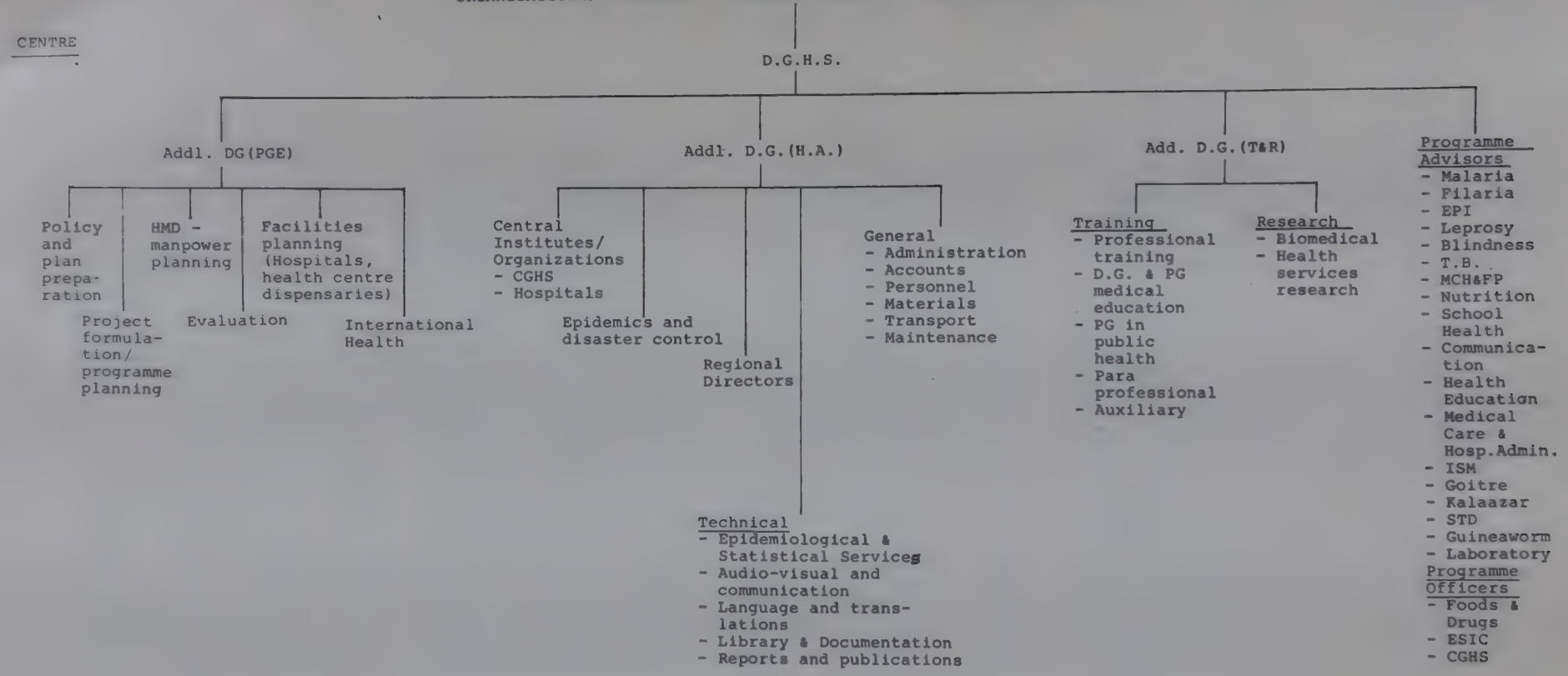
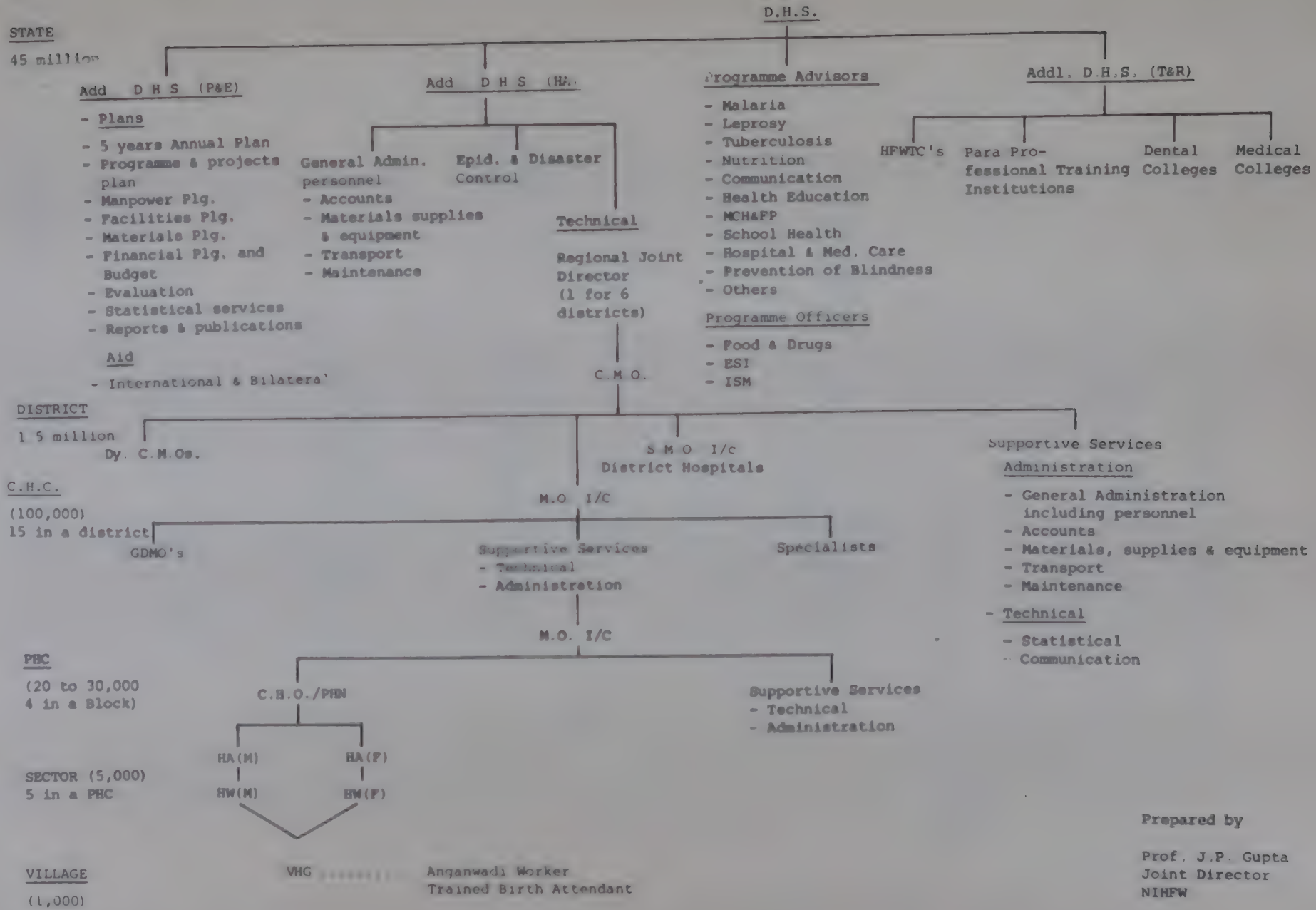
ORGANISATIONAL STRUCTURE AT VARIOUS LEVELS OF ADMINISTRATIVE SET-UP

ANNEXURE 1






Prepared by

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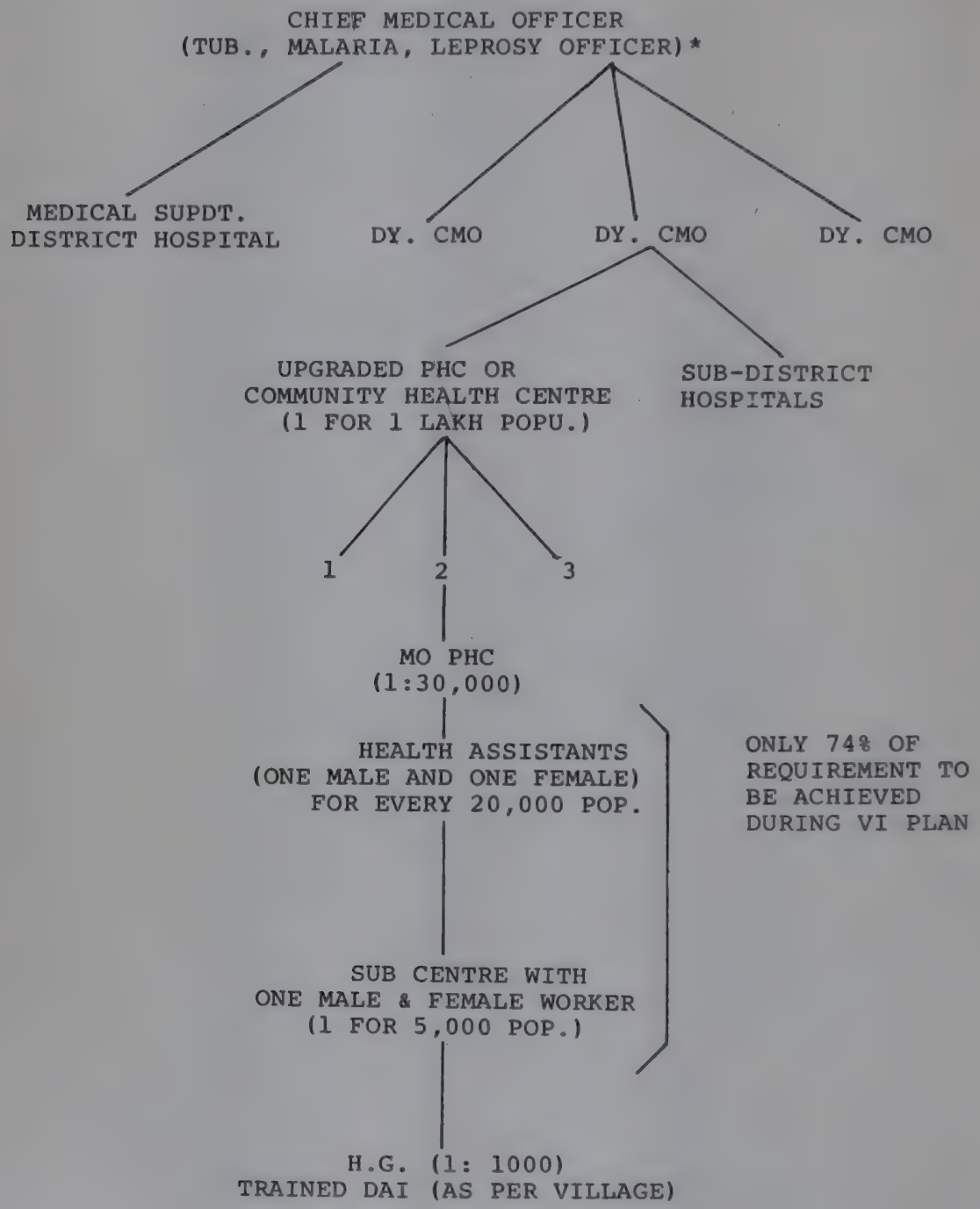
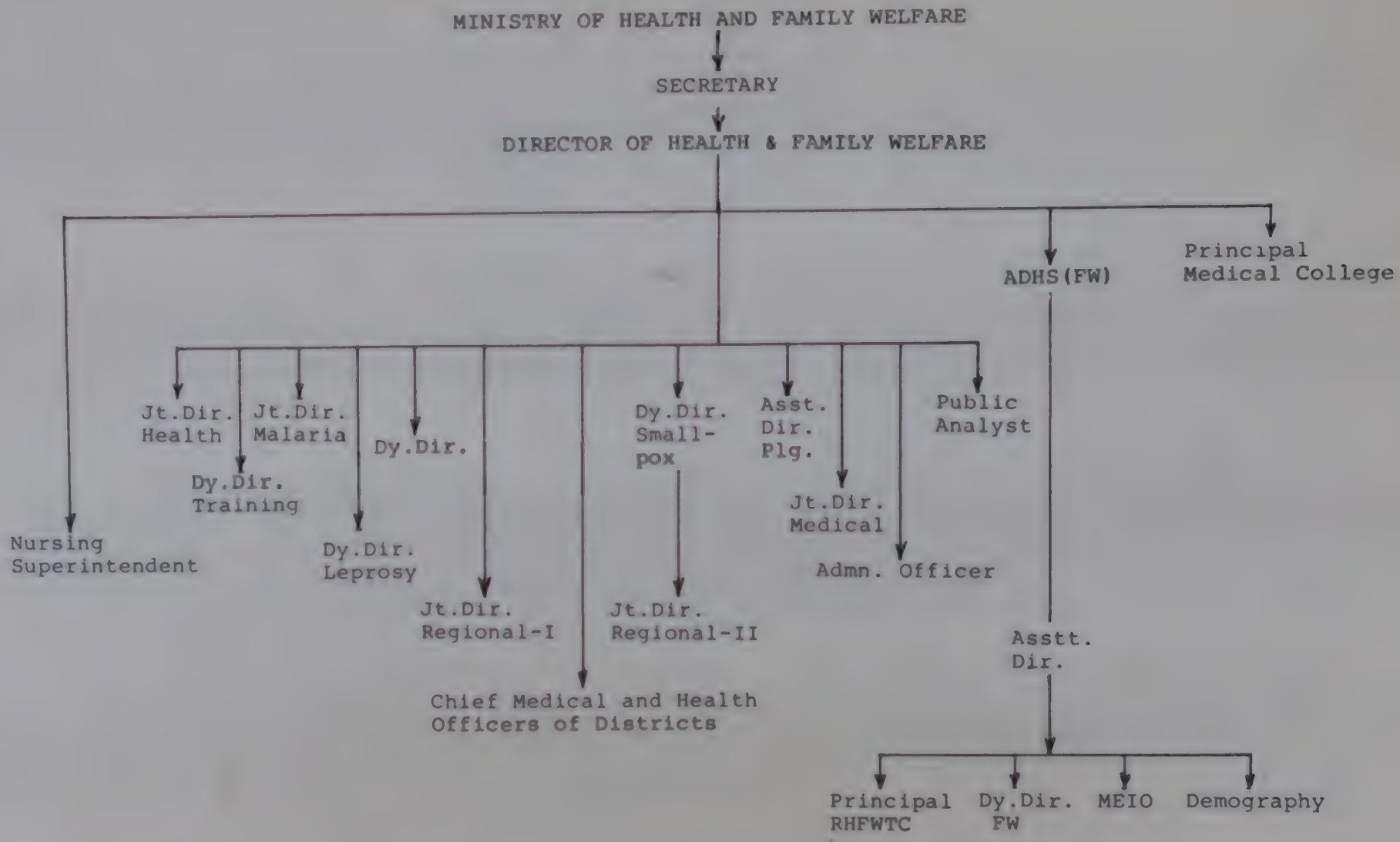
Joint Director
NIHFW

DISTRICT AND BELOW ORGANIZATION
APPROVED UNDER VI FIVE YEAR PLAN




*WHEREVER IN
POSITION

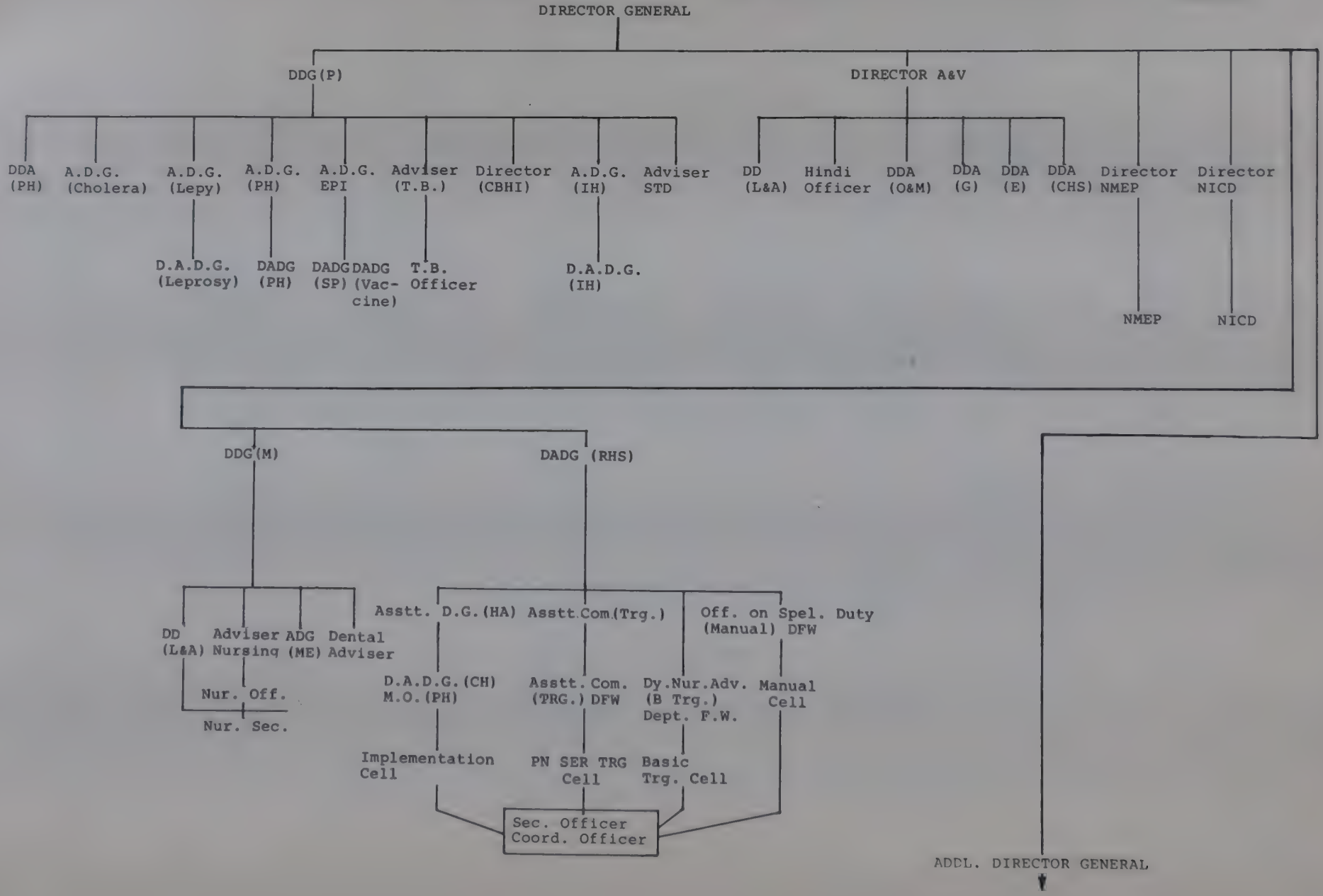
## ORGANIZATIONAL CHART OF DIRECTORATE OF HEALTH SERVICES - STATE

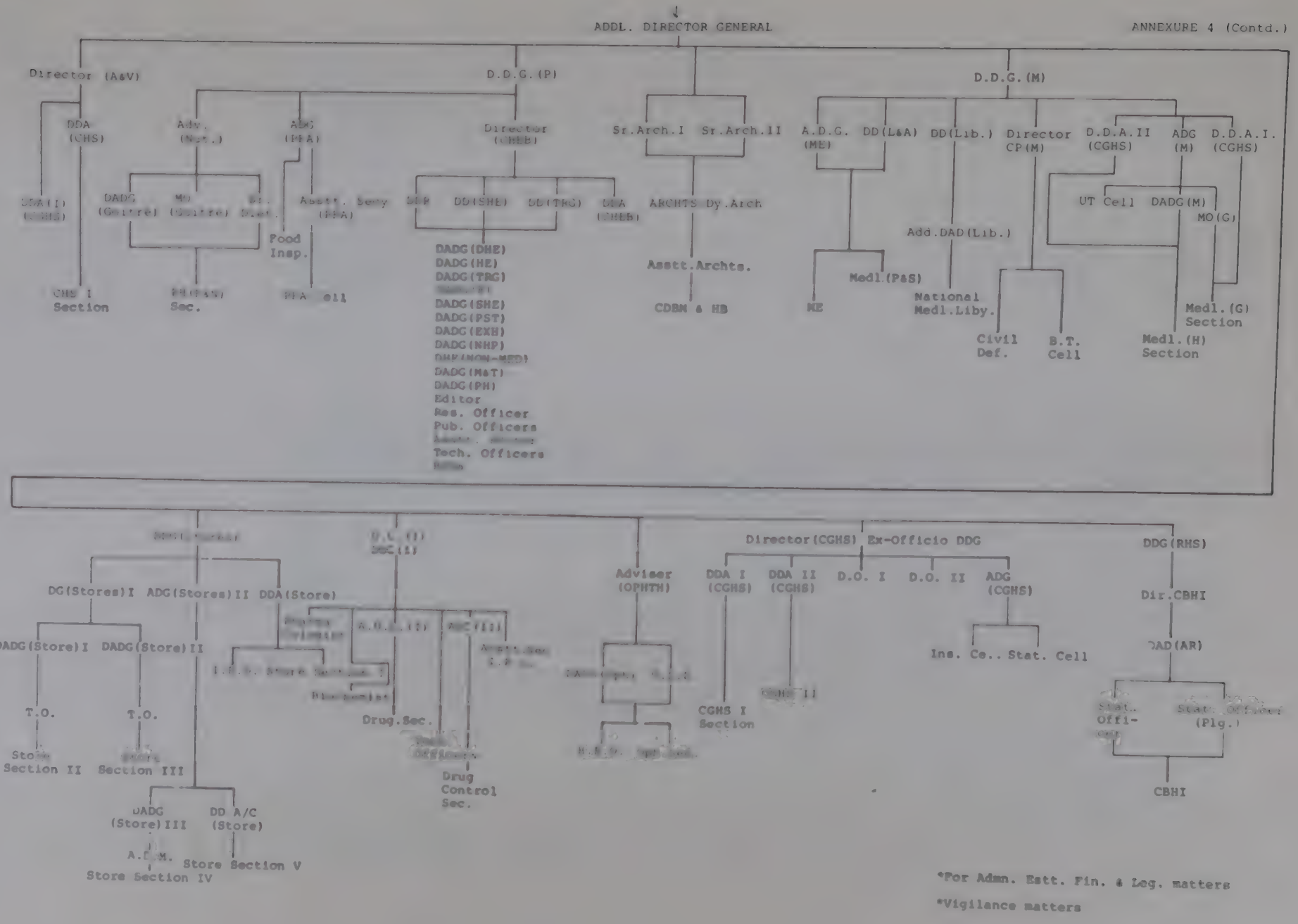


ORGANISATIONAL CHART

DIRECTORATE GENERAL OF HEALTH SERVICES

ANNEXURE 4






*For Admn. Estt. Fin. & Leg. matters

*Vigilance matters

ANNEXURE 5

DISTRIBUTION OF POSITIONS IN HEALTH SECTOR BY MANAGERIAL RESPONSIBILITIES

| S.No. | Level of Administrative set-up | Positions | Degree of managerial responsibility | Degree of responsibility in various components of managerial processes | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Policy formulation | Broad Programming | Detailed Programming | Implementation | Evaluation |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 1. BLOCK | PHC | MO I/C | ++ | | | | ✓ | |
| | | MOs | + | | | | | |
| | | CHO | +++ | | | | ✓ | |
| | CHC | MO I/C | +++ | | | | | |
| | | Other MOs | + | | | | | |
| | | Specialists | + | | | | | |
| | | Others | + | | | | | |
| 2. TALUK | S.D. | MO I/C | ++ | | | | ✓ | |
| | HEALTH CENTRE | MOs | + | | | | | |
| 3. DISTRICT | HOSPITAL | MS/SMO | + | | | | | |
| | | Specialists | + | | | | | |
| | | MOs | + | | | | | |
| | HEALTH | Nursing Staff | ++ | | | | ✓ | |
| | | CMO | +++ | | | | ✓ | |
| | | Dy. CMOs | +++ | | | | ✓ | |
| | | DFWO | +++ | | | | ✓ | |
| | | TB Officer | ++ | | ✓ | ✓ | ✓ | ✓ |
| | | School Health Officer | ++ | | | | | |
| | | Malaria Officer | ++ | | | | | |
| | | | | | | | | |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| | | Nursing Officer | +++ | | | | | |
| | | Other Programme Officer | ++ | | | | | |
| 4. DIVISION/REGIONS OFFICE | | Regional Director | +++ | | ✓ | ✓ | | ✓ |
| | | Other Officer | ++ | | | | | |
| | HFWTC | Principal Other | +++ | | | | | |
| | | Trainers | ++ | | | | ✓ | |
| 5. STATE | Office | DHS | | ✓ | ✓ | ✓ | | ✓ |
| | | Addl./Jt. Director | | ✓ | ✓ | ✓ | | ✓ |
| | | Programme Officers | +++ | ✓ | ✓ | ✓ | | ✓ |
| | | Other Officers | | ✓ | ✓ | ✓ | | ✓ |
| | Lab. | I/C State Lab. | ++ | | ✓ | ✓ | ✓ | ✓ |
| | | Other Officer | + | | | | | |
| | Hospital a. General | MS | +++ | | | | | |
| | | Other Officer | + | | | | | |
| | | DMS | +++ | | | | | |
| | b. Specialised | MS | +++ | | | | | |
| | | DMS | +++ | | | | | |
| | | Other Officers | + | | | ✓ | ✓ | |

3

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| | Medical College | Principals/ Deans | +++ | ✓ | | ✓ | ✓ | |
| | | Prof. P&SM | +++ | | | | | |
| | | Other faculty members | + | | | | | |
| | Mobile Unit | Incharge | ++ | | | ✓ | ✓ | |
| | Hospital | MS | +++ | | | ✓ | ✓ | |
| | | DMS | +++ | | | ✓ | ✓ | |
| | | Specialists | + | | | | | |
| 6. MUNICIPAL | Health | MHO | +++ | | ✓ | ✓ | ✓ | ✓ |
| | | Dy. HO's | +++ | | | ✓ | ✓ | ✓ |
| | | DFWO | +++ | | | ✓ | ✓ | ✓ |
| | | Epidemiologist | +++ | | | ✓ | ✓ | ✓ |
| | | Prof. Officers | +++ | | | ✓ | ✓ | ✓ |
| | | I/C PH Lab. | ++ | | | ✓ | ✓ | ✓ |
| | Hospital | | | | | | | |
| | Small | MO I/C MS | + | | | ✓ | ✓ | |
| | Medium | MO I/C MS | ++ | | | | | |
| | Large | MO I/C MS | +++ | | | | | |
| 7. REGION | Office | Regional Director | +++ | ✓ | | | | ✓ |
| | | Other Officers | ++ | | | | | |
| | | | | | | | | |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| 8. CENTRE | ADG/AC | D.G. | +++ | ✓ | ✓ for Centrally | ✓ | ✓ for Central | ✓ |
| | | Addl./DDG/DC | +++ | ✓ | ✓ sponsored | ✓ | programme ✓ | ✓ |
| | | AC | +++ | ✓ | ✓ people | ✓ | ✓ Institutions | ✓ |
| | | ADG/AC | +++ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | | DADG/DAC | +++ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | | Other Officers | +++ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | | a. Media | | ✓ | ✓ | ✓ | | |
| | | b. Nursing | +++ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | | c. Drugs | +++ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | | d. Food | +++ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | | Other technical staff | ++ ++ ++ | | | | | |
| 9. MISCELLANEOUS | CTI's | Director | +++ | ✓ | ✓ | | ✓ | ✓ |
| | | Other Officers | ++ | | | | | |
| | Specialised Institutions | Director | +++ | ✓ | ✓ | | ✓ | ✓ |
| | | Other Officers | + | | | | | |
| | PGI's | Director | +++ | ✓ | | | ✓ | ✓ |
| | | Other Officers | + | | | | | |

Key + Minimum/Peripheral management responsibility
++ Moderate/Primarily managerial responsibility
+++ Strong/Entirely managerial responsibility

ANNEXURE 6

## CONTENTS FOR DIPLOMA LEVEL COURSES

1. *Basic Sciences of Community Health "Supplemental and Review Subjects"*

Since too much of the academic year is currently spent in supplemental and review subjects, steps should be taken to:

a. Strengthen undergraduates teaching in the Department of Social and Preventive Medicine so that review and supplemental training will not be necessary.

b. For those inadequately prepared provide and promote teaching through programmed instruction. As a long-term goal the supplemental subjects should be completely removed from the content of a diploma course within a period of ten years. During this period the departments of social and preventive medicine in particular and medical colleges in general will strengthen their undergraduate teaching in these subjects.

2. ***Skills and Knowledge essential to "Essential Subjects" Administrative Leadership***

These must be thoroughly covered and form the core of the diploma course.

a. Community structure and organisation

b. Group psychology and group dynamics

c. Inter-personnel and inter-group relations

d. Power structure, political structure

e. Community development and community diagnosis

f. Newer methods and science of public administration management technique including hospital administration, budgets, records, supportive supervision and planning and evaluation.

g. Communication science, health education, mass media, visual aids as used in community organisation and development.

h. An introduction to scientific process as it applies to operational research.

3. *Skills and Knowledge Essential to "Introduction to Specialities in Community Health Speciality"*

Specialisation in a particular speciality is not the major objective of the diploma level education but an introduction to some speciality areas need to be provided, the training for which should not exceed three months. Such as:

a. Epidemiology

b. Maternal and Child Health and Family Planning

c. Environmental Health

d. Medical Care and Hospital Administration

e. Nutrition

f. Health Education

g. Industrial or Occupational Health and

h. Others.

OTHERS IN THE SERIES

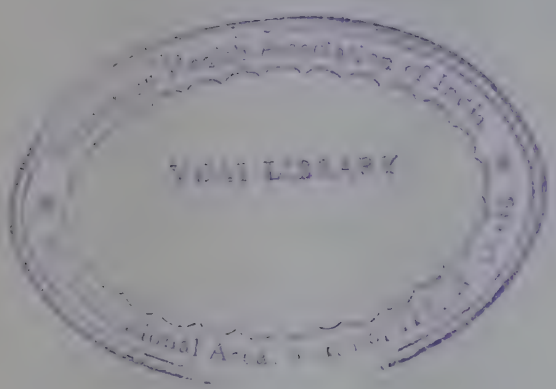
1. Health for all by 2000 AD - Problems, approaches and challenges.

2. Introductioin of contraceptives in national family planning programme: Injectables and implants.

3 Reorganization and reorientation of the health services delivery system in India.

4. Development and use of indicators and informatioin relating to maternal and child health care in India.

5. Primary health care in India.



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Reorganization and Reorientation of the Health Services Delivery System in India